

QUESTIONS AND ANSWERS ON THE HEART DISEASE, CANCER, AND STROKE AMENDMENTS OF 1965 REGARDING REGIONAL MEDICAL PROGRAMS

Passage of the Heart Disease, Cancer, and Stroke Amendments of 1965 (Public Law 89-239) has elicited many questions concerning its provisions and operation. Since the legislation was passed very recently, implementing regulations have not yet been formulated. These regulations will amplify the provisions and administration of this legislation, and they will be essential to a full understanding of the regional medical programs. However, the following answers to some typical questions have been supplied by the Office of the Director, National Institutes of Health, Public Health Service.

What are the purposes of the program?

Basically, to provide support for cooperative arrangements among medical institutions and practitioners which are planned and established on a regional basis to make the latest advances in diagnosis and treatment of heart disease, cancer, and stroke available to their patients.

What is the relationship between this program and the proposals of the President's Commission on Heart Disease, Cancer, and Stroke?

The program embodies the primary thrust of the first three recommendations of the Commission.

What is the relationship of this program to existing Federal health programs?

This program is not intended to supersede or absorb existing Federal health programs but rather to build on the capabilities created and strengthened through those programs and to draw upon their accomplishments.

How is "region" defined?

A "region" is a geographic area composed of part or parts of one or more States which the Surgeon General of the Public Health Service determines to be appropriate for purposes of the program.

How is "regional medical program" defined?

The law defines "regional medical program" as a cooperative arrangement among a group of public

or nonprofit private institutions or agencies engaged in research, training, diagnosis, and treatment relating to heart disease, cancer, or stroke, and, at the option of the applicant, related disease or diseases.

For what purpose will grants be made under the program?

Grants will be made for planning, feasibility studies, and operation of pilot projects for the establishment of regional medical programs of research, training, and demonstrations of patient care in the fields of heart disease, cancer, stroke, and related diseases.

Who is eligible to apply for grants under the program?

Any public or nonprofit private university, medical school, research institution, or other public or nonprofit private institutions and agencies interested in planning, conducting feasibility studies, and in operating regional medical programs of research, training, and demonstration activities in their own region of the nation.

What requirements must an application for a planning grant meet?

Applications must contain or be supported by reasonable assurances with respect to use of funds for the purposes stipulated, fiscal control and fund accounting, certain reporting and recordkeeping, and designation of an advisory group to advise in formulating and carrying out the proposed plan.

What kind of activities can be supported by grant funds?

Grants may be made to pay all or part of the cost of the planning and other activities related to establishment of the regional medical program. Funds for renovations and built-in equipment, however, may not exceed 90 percent of their cost.

Can new facilities be built under the program?

No. Where construction of new facilities is considered necessary for furthering the program, the applicant may seek construction funds under other applicable Federal programs, such as the Hill-

Burton, the Health Research Facilities, and the Health Professions Educational Assistance programs.

What kind of construction does the program permit?

Under the law, "construction" includes alteration, major repair (to the extent permitted by regulations), remodeling and renovation of existing buildings (including initial equipment thereof), and replacement of obsolete, built-in (as determined in accordance with regulations) equipment of existing buildings.

What elements will a regional medical program contain?

Within the general guidelines provided by the law, the specific content of a regional medical program will be determined by local action according to the needs, opportunities, and resources unique to that region. The institutions involved will include one or more medical centers, one or more clinical research centers, and one or more hospitals.

What types of activities can be included in a regional medical program?

Among the types of activities which can be included are continuing education for medical personnel, interchange of personnel among participating institutions, wider distribution of the latest diagnostic and treatment techniques including the necessary equipment and trained personnel, and the development of new approaches to the problems of clinical training and clinical research.

What kind of institution will be responsible for the management of the regional medical programs?

This will be decided according to the local plans of the participating institutions and the local advisory group.

How many regional medical programs will be established?

The number of regional medical programs established on a pilot basis during the 3-year period authorized in this legislation will depend on application received, action by the National Advisory Council on Regional Medical Programs, and final award of the grant by the Surgeon General.

Who will prescribe the regulations covering approval of grant applications?

The Surgeon General, after consultation with, and advice from, the National Advisory Council.

What will be the composition of the National Advisory Council?

It will consist of the Surgeon General, as chairman, and 12 leaders in the fundamental sciences, the medical sciences, or public affairs. Specifically, one of the members must be outstanding in the field of heart disease, one in cancer, and another in stroke, and two additional members must be practicing physicians.

What does a local advisory group consist of?

The local advisory group should include interested health groups: representatives of the practicing physicians of the region, medical centers, hospitals, medical societies, voluntary health agencies, and other interested parties such as public health officials and members of the public.

How will the funds available under the program be distributed?

The distribution of these funds will not be definitely known until applications are received and considered by the National Advisory Council. Initial emphasis on grants for planning and feasibility studies is anticipated.

Can these funds be used to pay for patient care?

These funds can be used to pay the costs of patient care only when such care is incident to research, training, and demonstration activities.

When is a patient eligible for such care?

When referred by a practicing physician. The law reads: "No patient shall be furnished hospital, medical, or other care at any facility incident to research, training, or demonstration activities carried out with funds appropriated pursuant to this title, unless he has been referred to such facility by a practicing physician."

When will grant applications be accepted?

As soon as the prerequisite administrative mechanisms have been completed. It is believed that the appointment of the Advisory Council, establishment of regulations, preparation of application forms, and so forth, will be accomplished in the next few days.

Where can prospective applicants send for further information?

Inquiries may be addressed to the Associate Director for Regional Medical Programs, National Institutes of Health, Bethesda, Md. 20014.



Shingles (Herpes Zoster). Hope through research. *PHS Publication No. 1308, Health Information Series No. 125; 1965; leaflet; 5 cents, \$3.25 per 100.* Describes the disease and advises victims to consult a physician. Suggests that particular attention be given shingles rash appearing on the face; if the rash affects the eyes or ears, an ophthalmologist or an otologist should be consulted. Explains the researchers' theories on the cause of shingles. Gives no specific treatment but mentions the use of lotions and drugs to relieve pain. Also mentions that gamma globulin given the first few days or that treatment with immune serum taken from patients recovering from shingles has been effective in some cases.

Little Strokes in Dental Patients. *PHS Publication No. 1385; 1965; leaflet; 5 cents, \$2 per 100.* Alerts the dentist and other health professionals to the role of the dentist in detecting the signs and symptoms of mild cerebrovascular attacks. Provides guidelines for the prevention of transient ischemic attacks in patients in the dental chair.

Rural Home Nursing Care for Long-Term Illness. *PHS Publication No. 1344-1; October 1965; 24 pages; 15 cents.* First of a series of "Portraits in Community Health." Tells how relatively small amounts of Federal money can help a community develop needed services for long-term-illness

patients. Relates the story of how the local health department in Ouachita County, Ark., launched the first rural home-nursing service in that State and became the prototype for 25 other counties now offering similar services to the chronically ill and aged.

Chronic Bronchitis and Emphysema. *PHS Publication No. 1103-F; 1965; leaflet; 5 cents, \$2 per 100.* Describes chronic bronchitis and emphysema and the relationship of cigarette smoking to the rapid increase in deaths from these diseases. Calls attention to the Surgeon General's Advisory Committee report of January 1964, in which studies of more than a million men revealed that the death rate from chronic bronchitis and emphysema among cigarette smokers was six times greater than for nonsmokers.

Research in Nursing: 1955-1965. *PHS Publication No. 1356; May 1965; 67 pages.* Presents a summary listing of projects sponsored by the Division of Nursing from 1955-1965. Describes projects in three broad areas: organization, distribution, and delivery of nursing services; recruitment, selection, education, and characteristics of the nurse supply; and nursing research development (research conferences, development of research tools, experimental faculty research development projects). Gives project title,

brief description of each project, and citations to publications resulting from the research.

Home Nursing Course Instructors' Guide. *PHS Publication No. 1339; 1965; 61 pages; \$1.* Presents material for teaching home-nursing techniques to persons with limited education, who lack basic medical knowledge, and who sometimes have a language barrier. This manual is the result of a pilot training program conducted on the Whiteriver Apache Indian Reservation in Arizona for the purpose of developing a teaching manual for training instructors, who in turn could instruct others.

Cancer of the Colon and Rectum. *PHS Publication No. 1304; 1965; leaflet; 5 cents, \$2.75 per 100.* Gives symptoms, diagnosis, and treatment of cancer of the colon and rectum and discusses related conditions and current research. Recommends that rectal examination with a sigmoidoscope be included in the annual physical checkup of everyone over 40 to help detect tumors early. Also discusses advances in surgical techniques and reasons for improved survival rates.

This section carries announcements of new publications prepared by the Public Health Service and of selected publications prepared with Federal support.

Unless otherwise indicated, publications for which prices are quoted are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402. Orders should be accompanied by cash, check, or money order and should fully identify the publication. Public Health Service publications which do not carry price quotations, as well as single sample copies of those for which prices are shown, can be obtained without charge from the Public Inquiries Branch, Public Health Service, Washington, D.C., 20201.

The Public Health Service does not supply publications other than its own.

CROCKETT, ANNEMARIE F. (Johns Hopkins University School of Hygiene and Public Health): *Cardiac diagnostic and surgical facilities in the United States. Public Health Reports, Vol. 80, December 1965, pp. 1035-1053.*

A questionnaire survey of 6,988 hospitals in the 48 contiguous States resulted in the identification of 540 cardiac catheterization laboratories, 686 angiocardiology laboratories, 348 open cardiac surgical facilities, and 825 closed cardiac surgical facilities in 1961. No procedures were performed in 1961 by 18 percent of the cardiac catheterization laboratories, 33 percent of the angiocardiology laboratories, 11 percent of the open cardiac surgical facilities, and 29 percent of the closed cardiac surgical facilities. Reporting from 1 through 49 procedures for the year were 52 percent of the cardiac catheterization laboratories, 74 percent of the angiocardiology laboratories, 74

percent of the open cardiac surgical facilities, and 87 percent of the closed cardiac surgical facilities. The overwhelming proportion of all procedures was reported by hospitals providing all four facilities and located in large urban centers. Well over half of the procedures reported were performed for patients with congenital rather than acquired heart disease. Further research is needed to investigate the relationship between the frequency the procedures are performed and surgical mortality and to obtain information about personnel, type of equipment, and auxiliary services available.

ZIMMERMANN, W. J. (Iowa State University of Science and Technology), and **BRANDLY, PAUL J.:** *The current status of trichiniasis in U.S. swine. Public Health Reports, Vol. 80, December 1965, pp. 1061-1066.*

A total of 21,417 swine diaphragms were examined for *Trichinella spiralis* from April 1961 through March 1965. The swine were from all geographic areas of the United States.

Results of the examinations indicated that the current incidence of *T. spiralis* in farm-raised pigs is low; only 0.12 percent of 9,495 butcher swine and 0.22 percent of 6,881 breeder swine were infected. The incidence in garbage-fed pigs is markedly higher; 2.6 percent of 5,041 diaphragm samples contained trichinae. Although the overall incidence for garbage-fed swine is high, trends were noted which may indicate a decline in incidence. During this approximately 4-year study,

the incidence for garbage-fed swine in a New England State declined from 6.3 percent to 0.4 percent, and in a Middle Atlantic State it decreased from 5.1 percent to 0.5 percent.

The larvae per gram counts for the farm-raised pigs were low; 23 of 26 infected diaphragm samples contained less than 1 larva per gram. For garbage-fed swine, the concentration of larvae per gram was higher; only 79 of 131 infected samples contained less than 1 larva per gram. Each of three diaphragms from garbage-fed swine contained more than 500 larvae per gram; the maximum was 2,800.

ELVEBACK, LILA (Mayo Clinic), and **VARMA, ANDRÉ:** *Simulation of mathematical models for public health problems. Public Health Reports, Vol. 80, December 1965, pp. 1067-1076.*

The increasing availability of large electronic computers has given great impetus to the use of simulation of stochastic models as a means of obtaining information, otherwise inaccessible, related to problems in public health and the medical sciences. The general nature of model building and simulation are discussed, and examples from the literature illustrate the broad range of problems in

which the method already has proved useful. Using the familiar Reed-Frost epidemic model as an example, the entire process of obtaining probability distributions of total number of cases and duration is presented, along with results of the simulation procedure. An extension of the Reed-Frost model for the study of interference between viral agents is discussed.

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DOFF, S. D. (Duval Medical Center, Jacksonville, Fla.), JACKSON, E. RUSSELL, LENDRUM, JAMES T., and GROBE, WILLIAM C.: *Orienting the architect to nursing home design. Public Health Reports, Vol. 80, December 1965, pp. 1077-1082.*

Despite prolonged educational efforts of the division of hospitals and nursing homes of the Florida State Board of Health and a licensure requirement that nursing home plans be prepared by registered architects or engineers, the board continued to receive plans revealing misconceptions about nursing home functions.

Therefore, with the help of the Florida Nursing Home Association, the State's department of welfare and board of nursing, and the University of Florida, the board of health initiated several planned education projects on nursing homes. In one project, meetings for practicing architects and engineers were organized. In

another, a graduate student of the university's department of architecture was assigned for 2 months in 1962 as a trainee to the State's division of hospitals and nursing homes. After orientation, he was assigned two simulated problems of nursing home design. On a trial basis, during the 1963 spring trimester, five undergraduates were provided background for such designing in course curriculums of the university's department of architecture.

It was planned in 1965-66 to assign 22 fourth-year architectural students the design of a teaching and research nursing home for the university medical center.

DONABEDIAN, AVEDIS (University of Michigan), ROSENFELD, LEONARD S., and SOUTHERN, EDWARD M.: *Infant mortality and socioeconomic status in a metropolitan community. Public Health Reports, Vol. 80, December 1965, pp. 1083-1094.*

Data were obtained on the socioeconomic characteristics (1950 census) of 90 census tracts in a segment of Metropolitan Boston designated as the study area and the fetal and infant deaths occurring to mothers who resided in those tracts. These were used (a) to plot the geographic distribution of perinatal mortality in the study area, and (b) to study the relationships between the various mortality rates and socioeconomic status.

The findings show a fivefold difference in perinatal mortality between the census tracts with the highest and the lowest socioeconomic status, and a sharp geographic localization of the areas of highest mortality. In the census tracts with the highest mortality, the component

segments of infant mortality were proportionately related to one another in a manner similar to the pattern in partially developed countries today and of the United States as a whole several decades ago.

All segments of mortality decreased markedly as socioeconomic status improved, except for deaths during the first week of life which remained at an even level. Analysis of the data suggests that a systematic misclassification of stillbirths as first-week deaths (or the reverse) is the least likely explanation, and the deferral of perinatal deaths among the high socioeconomic groups the most likely explanation of the findings.

WAGSTAFF, D. J. (Public Health Service), JANNEY, J. H., CRAWFORD, K. L., DIMIJIAN, G. G., and JOSEPH, J. M.: *Q fever studies in Maryland. Public Health Reports, Vol. 80, December 1965, pp. 1095-1099.*

Q fever studies in Maryland in 1963 revealed that a major source of possible human infection was infected dairy cattle. Of 2,065 herd milk samples tested, 72.4 percent were CA positive. Seven isolations of *Coxiella burnetii* were made from these samples. Serologic evidence of exposure was obtained from: (a) a survey of farm residents exposed to infected cattle, in which 15.3 percent of 124 people tested were CF positive; and (b) a survey of the general population of the State,

which showed that of 23,283 serums tested, 0.35 percent were CF positive.

Serologic reaction appeared to be related to residence or employment in the vicinity of infected dairy cattle. No acute illness attributable to Q fever was reported by any of the serologically positive people who were interviewed. An isolation of *C. burnetii* was made from a person with no reported acute illness, suggesting that asymptomatic infections may have occurred.

REED, DWAYNE (Public Health Service), and BRODY, JACOB A.: *Use of blood collected on filter paper disks in neutralization tests for poliovirus antibody. Public Health Reports, Vol. 80, December 1965, pp. 1100-1102.*

Routine neutralization tests for the three types of poliovirus antibody were performed on children at the Public Health Service Alaska Native Medical Center in Anchorage. A simplified method of collecting a small amount of blood on filter paper disks was used. Results obtained were almost identical to those

obtained with the use of serum.

A new method to remove eluate from the disks with a disposable syringe increased the amount of fluid recovered from the disks and permitted the performance of at least three neutralization tests on the usual three-disk specimen.

DRENCKHAHN, VIVIAN V. (University of Hawaii): *Educational role of the nurse in chronic disease control. Public Health Reports, Vol. 80, December 1965, pp. 1103-1106.*

As the nurse provides a service to a patient or his family, she can also be teaching. Service and education go hand in hand; one enhances the other. To insure that such education of patients and families is carried out, that it is dynamic and effective, the nurse must make plans for it. The teaching needs to be personalized to meet the needs of a given patient or group. As far as possible patients should participate in all phases of educational activities. They may help in identifying their interests and needs

and in setting goals. They may also take part in the programs themselves, for example, by demonstrating a procedure after the nurse has demonstrated it.

To insure clear communication between nurse and patient, visual aids and other educational methods may be used to supplement the spoken word. The most important aspect of teaching, however, is to develop in the patient such a friendly, cooperative attitude that he accepts the teacher's health message.

HOLMES, M. A. (Oregon State Board of Health), and BRANDON, GATLIN: *Pasteurella multocida infections in 16 persons in Oregon. Public Health Reports, Vol. 80, December 1965, pp. 1107-1112.*

A total of 16 human cases of *Pasteurella multocida* were diagnosed in Oregon between September 1962 and April 1965. Of these 16 cases, 5 resulted from cat bites, 1 from an ear infection with source unknown, 3 from dog bites, 3 from combined cat bites and scratches, and 3 from cat scratches only; in 1 case there was a history of chronic bronchitis.

In spite of intensive therapy in some

of these cases, the wound infections persisted. They remained painful, hot, red, and swollen, and frequently contained a dark and heavy, ill-smelling pus. Most patients recovered uneventfully and suffered no severe permanent damage from the infections. In only two instances was bacteremia or septicemia noted. There was no damage to the bony tissue beneath the wounds.